DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G114	A. BUILDING _____ B. WING _____	11/28/2007

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
JAN -3 P 3:52

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	2852 NORTHAMPTON ST, NW WASHINGTON, DC 20015

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W 000	INITIAL COMMENTS A recertification survey was conducted from November 26, 2007 through November 28, 2007. The survey was initiated using the fundamental survey process; however, due to the deficient practice in the Condition of Health Care Services, the survey process was extended. A random sample of two clients was selected from a resident population of four males with various disabilities. An additional client was added as a focus to determine if the client was provided with the necessary adaptive equipment. The survey findings were based on observations in the group home and two day programs, and interviews with clients, residential, day program, nursing and administrative staff. Review of records, including review of unusual incidents was also conducted. The facility was deficit in the Conditions of Participation in Governing Body, and Health Care Services.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility's governing body failed to provide general operating directions over the facility as evidenced the deficiencies cited throughout this report.	W 104	W104 The governing body of MTS has taken the steps necessary to address the immediate concerns outlined in this survey and the systemic issues raised by the survey deficiencies as evidenced by the corrective actions outlined throughout this response document.....1-2-07.	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gretta K. Moore
TITLE: Director of Residential Services
(X6) DATE: 1/2/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for one of two clients in the sample. (Client #2) and one focus client. (Client #3) The findings include: 1. Observation during breakfast at the group home on November 26, 2007 at approximately 6:35 AM revealed that ~~Client #3 was served~~ a pureed diet from a high sided plate. In an interview with the day program staff, on November 26, 2007 at approximately 1:40 PM, it was revealed that Client #3 was served a pureed diet from an "interlip plate". Further interview and record review revealed that Client #3 had mealtime protocol at the day program dated February 1, 2007 which indicated that the client's adaptive equipment was a plate guard and a regular cup with a straw. Review of the Occupational Therapist (OT) Assessment dated June 16, 2007, on November 26, 2007 at approximately 3:30 PM revealed that Client #3 was recommended to use a high sided plate at mealtime. There was no evidence Client #3 was served a pureed diet from a high sided plate as recommended by the OT in the day program. 2. Observation at the day program on November 26, 2007 at approximately 12:05 PM revealed that Client #2 was walking out of the dining room and attempted to inappropriately touch a female peer before she moved beyond his reach. Interview with the Program Manager November 26, 2007 at approximately 12:35 PM revealed that	W 120	W120 1. MTS will insure that the day program of client #3 has the same type of high sided plate used at home and will purchase one for the program if need be by...12-30-07. The QMRP will visit the program at minimum once monthly to insure that the program staff is routinely using the proper plate and following the prescribed diet...12-30-07. 2. The QMRP will meet with the day program of client #2 to insure that staff uses the ABC data collection forms to document the targeted behaviors. MTS will supply the program with copies of the form and instruct staff on it s use...12-30-07. The QMRP will also review this issue during monthly visits thereafter and will check the periodic day program reports to insure that they cover the issue in data-based manner.....1-2-07.	

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W 120	Continued From page 2 Client #2 has targeted behaviors that include inappropriately touching. Further interview revealed that the day program did not document Client #2's targeted behaviors on the Antecedent Behavior Consequence (ABC) forms when they are exhibited. Review of Client #2's Psychological Assessment dated July 1, 2007 on November 27, 2007 at approximately 1:10 PM revealed that Client #2 has targeted behaviors that included inappropriate touching, physical aggression, verbal aggression, hallucinations and property destruction. Review of Client #2's Behavior Support Plan (BSP) dated June 30, 2007 on November 27, 2007 at approximately 1:15 PM revealed that targeted behaviors were to be recorded on the ABC forms.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for two of the two clients in the sample. (Client #1 and Client #2) The findings include: 1. Client #1 was observed during the morning	W 124	W124 1. MTS will review the sedation issue with Client #1's mother and if she agrees, will obtain her signature on the new sedation consent form developed and included as an attachment....12-30-07. In addition, MTS will explore the possibility of Client #1's mother accepting the status of legal guardian for him. If she agrees, the QMRP will work with the DDS case manager to process paperwork to establish guardian status for the mother. If agreed upon, paperwork will be submitted by 1-2-08. The QMRP's notes will reflect the status of progress...1-2-08	

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W 124	Continued From page 3 medication pass on November 26, 2007 at approximately 7:45 AM being administered Ativan 4 mg by mouth. Interview with the Registered Nurse (RN) on November 26, 2007 at approximately 8:00 AM revealed that Client #1 was prescribed the sedation for a dental examination. Interview with the Qualified Mental Retardation Professional (QMRP) on November 26, 2007 at approximately 9:00 AM revealed that Client #1's mother was very involved in his life but is not the client's legal guardian. Review of Client #1's, psychological assessment dated November 29, 2006 on November 27, 2007 at approximately 1:18 PM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #1's mother of the health benefits and risks of treatment associated with the use of the sedation. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2. Client #2 was observed during the evening medication pass on November 26, 2007 at approximately 6:35 PM and was administered Haldol 15 mg by mouth twice a day and Depakote 500 mg by mouth twice a day. Review of Client #2's physician's orders dated October 1, 2007 revealed that the client was prescribed Haldol 15 mg by mouth twice a day and Depakote 500 mg by mouth twice a day for the management of Schizophrenia. Interview with the Licensed Practical Nurse (LPN) on November 26, 2007 at approximately 6:40 PM revealed that Client #2 was prescribed these medications for behavioral management. Further interview with the LPN	W 124	2. MTS will insure that the medical team discusses the psychotropic medication regimen and BSP of Client #2 with the parents. If the parents agree that the BSP and psychotropic drug regimen are reasonable strategies to address Client #2's behavior issues, MTS will insure one signs the newly-developed consent form for BSPs and psychotropic medication regimens by...1-2-07. The QMRP notes will reflect the status of progress...1-2-07.	

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W 124	Continued From page 4 revealed that the medications were incorporated into Client #2's Behavior Support Plan (BSP) dated June 30, 2007 to address targeted behaviors that included inappropriate touching, physical aggression, verbal aggression, hallucinations and property destruction. Interview with the QMRP on November 26, 2007 at approximately 9:30 AM revealed that Client #2's parents are very involved in his life but are not the client's legal guardians. Review of Client #2's, psychological assessment on November 27, 2007 at approximately 1:21 PM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #2's parents of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and review of records, the facility failed to establish and maintain a system that ensures a complete and accurate accounting of clients' funds that are entrusted to the facility for two of two clients included in the sample. (Client #1 and #2)	W 140		

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W 140	Continued From page 5 The finding includes: 1. Review of Client #1's Individual Support Plan (ISP) record dated December 11, 2006 on November 28, 2007 at approximately 1:36 PM revealed a bank statement ending November 16, 2007 in the financial section. According to the statement, there were several deposits of Social Security Income (SSI) in the amount of $70.00 deposited in Client #1's account from January 2007 through October 2007. Further review revealed a withdrawal in October 2007 for the amount of $500.00 dollars. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 1:40 PM revealed that the money withdrawn was spent on Client #1's vacation to New York City. Further interview with the QMRP revealed that the receipts were located in the main office and would be brought to the facility for review. By the end of the survey, the receipts were not made available for review to determine how the money was spent. 2. Review of Client #2's Individual Support Plan (ISP) record dated August 2007 on November 28, 2007 at approximately 1:36 PM revealed a bank statement ending November 16, 2007 in the financial section. According to the statement, there were several deposits of Social Security Income (SSI) in the amount of $70.00 deposited in Client #2's account from January 2007 through October 2007. Further review revealed a withdrawal in October 2007 for the amount of $500.00 dollars. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 1:40 PM revealed that the money withdrawn was spent on Client #2's vacation to New York City. Further interview with	W 140	W140 1 and 2. Copies of the vacation receipts are attached for clients #1 and #2. MTS will insure that personal funds use receipts are reconciled in a timely manner in the future. MTS has assigned this task to a specific member of the accounting office team and has revised its policies to reflect the regulatory mandates...12-30-07.	

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W 140	Continued From page 6 the QMRP revealed that the receipts were located in the main office and would be brought to the facility for review. By the end of the survey, the receipts were not made available for review to determine how the money was spent.	W 140		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's staff failed to implement it's incident management protocol for one of two clients in the sample (Client #1) and one focus client (Client #3), failed to implement it's policies on management of medications (Missed Medications, Disposal of Medications, and Medication Storage). The findings include: 1. On November 27, 2007 at approximately 11:00 AM a nursing progress note dated August 1, 2007 was reviewed and revealed that Client #1 was discovered to have two 5.5 cm scratches on his body. Interview with the Registered Nurse (RN) on November 27, 2007 at 2:10 PM revealed that she did not complete an unusual incident report after the incident was discovered. Review of the New Incident Management Protocol" dated September 2007 was reviewed on November 28, 2007 at approximately 11:13 AM. According to the protocol, "All incidents reports must be written and faxed to the Incident Management Coordinator." Further review of the protocol	W 149	W149 1. The DON will train nursing staff on the incident reporting mandates by.....12-30-07. 2. The IMC was not informed via incident report with 24 hours. The residential director has reinforced with the QMRP the importance of insuring that reports are submitted to the IMC immediately so that she can properly distribute them.....12-30-07. The residential director will reinforce this with the entire management team in the July 2008 team meeting...1-20-07.	

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W 149	Continued From page 7 revealed that "Serious Reportable Incidents" are due within 24 hours hours. There was no evidence that the facility's nursing staff implemented it's incident management policy. 2. Review of an unusual incident report dated May 26, 2007 on November 26, 2007 at approximately 8:17 AM revealed that Client #3 had sustained scratches on his penis and was transported to the emergency room for treatment. Further review revealed that the DOH was not made aware of the incident until June 4, 2007. There was no documented evidence that this incident had been reported to governmental agencies as required in a timely manner. 3. Observation of the medication cabinet contents on November 26, 2007 at approximately 10:10 AM revealed a blister pack containing Tylenol 325 mg tablets which had expired on April 7, 2007. In an interview with the RN on November 26, 2007 at approximately 10:15 AM it was acknowledged that the Tylenol 325 mg tablets medication had expired. Review of the facility's policy entitled "Disposal of Medications" dated January, 2006 on November 28, 2007 at approximately 11:13 AM revealed that all expired medications need to be returned to the pharmacy for disposal. There was no evidence that the facility staff implemented it's policy on discarding expired medications. 3. Observation of the medication pass on November 26, 2006 at approximately 6:55 PM revealed that the Licensed Practical Nurse (LPN) was unable to administer Lactulose 15 ml. by mouth to Client #1 because the medication was not available in the facility. In an interview with the LPN, it was acknowledged that the medication was not available in the facility because the	W 149		

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W 149	Continued From page 8 pharmacist was unable to deliver the medication on November 26, 2007. Further interview revealed that the Lactulose would be delivered by the pharmacy on November 27, 2007. Interview with the Registered Nurse (RN) and observation of the contents of the medication file cabinet on November 28, 2007 at approximately 10:17 AM revealed that Client #1's Lactulose had not been delivered to the facility. Review of the physician 's orders dated October 1, 2007, revealed an order to administer Lactulose 15 ml. by mouth every evening to Client #1. Review of a hospital discharge summary dated June 16, 2007 on November 27, 2007 revealed that Client #1 had a Supravalvar Pulmonary Stenosis/LPA Stenosis performed on June 15, 2007. Further review . revealed that Client #1 had a diagnosis of status post Pulmonary Balloon Valvuloplasty and LPA. Review of the facility's policy entitled "Missed Medications" dated January, 2006 on November 28, 2007 at approximately 11:15 AM revealed that all clients receive their required medication on a consistent basis as outlined in the approved physician's orders. Further review revealed that nursing personnel coordinate with the pharmacy and pharmacy personnel to ensure that medications were maintained in adequate supply at all times. There was no evidence that the facility staff implemented it's policy on "Missed Medications". 4. Observation on November 28, 2006, approximately between the hours of 4:05 PM-6:30 PM revealed that the combination lock that was used to secure the medication file cabinet located in the basement was lying on a counter top. Further observation revealed that at that same time period Client 's #1, #2, #3, and #4 and direct care staff were involved in various active	W 149	3. The Don will also reinforce with nursing the policy on discarding expired medications...12-30-07. The lead RN will review the medication cabinets at minimum monthly to audit for expired medications and pharmacy will do so quarterly...12-30-07. Lactulose had been ordered for client #1 and the home was awaiting delivery on the survey date. The RN called the pharmacy and was assured that it would be delivered that day in time for the pm dose. The pharmacy failed to deliver. Had the pharmacy indicated they could not deliver, MTS nursing would have picked up the medication as it has in the past. The medication was delivered the next day right after the surveyor departed and was given. MTS nursing will meet with the pharmacy to insure that medications are consistently delivered in a timely manner and that communication between MTS and the pharmacy is consistently accurate...12-20-07. The DON will review the MTS guidelines on medication administration with nursing...12-30-07. The Supravalvar Pulmonary Stenosis/LPA Stenosis procedure mentioned resolved the targeted issues...12-1-07. Nursing erred in leaving the medication exposed during the medication pass. As mentioned, the DON will reinforce the MTS medication administration guidelines with nursing and will insure that each MAR book has a copy of the guide in front...12-30-07.	

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W 149	Continued From page 9 treatment programs in the basement. The medication Licensed Practical Nurse (LPN) placed the combination lock on the medication file cabinet before going upstairs to wash her hands. In an interview with the Registered Nurse (RN) on November 27, 2006, at approximately 2:00 PM between the hours of 4:05 PM- 6:30 PM it was acknowledged that the medication file cabinet is to be locked at all times when medications are not being prepared. Review of the facility's policy entitled "Medication Storage" dated January 15, 2006 on November 28, 2007 at approximately 11:20 AM revealed that the nurse will ensure that all medications are to be stored in a locked area. There was no evidence that the facility nursing staff implemented it's policy on ensuring that all biological and drugs were locked when not being prepared.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: 1. On November 27, 2007 at approximately 11:00	W 153	W153 See responses for W149	

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W 153	Continued From page 10 AM a nursing progress note dated August 1, 2007 was reviewed and revealed that Client #1 was discovered to have two 5.5 cm scratches of unknown origin on his body. Interview with the Registered Nurse (RN) on November 27, 2007 at 2:10 PM revealed that she had not completed an unusual incident report for the facility's incident manager coordinator to forward to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required. 2. Review of an unusual incident report dated May 26, 2007 on November 26, 2007 at approximately 8:17 AM revealed that Client #3 had sustained scratches on his penis and was transported to the emergency room for treatment. Further review revealed that the DOH was not made aware of the incident until June 4, 2007. There was no documented evidence that this incident had been reported to governmental agencies as required in a timely manner.	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for four of four clients in the facility. (Client #1,Client #2, Client #3 and Client #4) The findings include:	W 159		

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W 159	Continued From page 11 1. The QMRP failed to coordinate services with Client #2's day program to ensure the use of the ABC forms to document his targeted behaviors as evidenced by: Observation at the day program on November 26, 2007 at approximately 12:06 PM revealed that Client #2 was walking out of the dining room and attempted to inappropriately touch a female peer before she moved beyond his reach. Interview with the Program Manager November 26, 2007 at approximately 12:35 PM revealed that Client #2 has targeted behaviors that include inappropriately touching. Further interview revealed that the day program does not document Client #2's targeted behaviors on the Antecedent Behavior Consequence (ABC) forms when they are exhibited. Review of Client #2's Psychological Assessment dated July 1, 2007 on November 27, 2007 at approximately 1:10 PM revealed that Client #2 has targeted behaviors that included inappropriate touching, physical aggression, verbal aggression, hallucinations and property destruction. Review of Client #2's Behavior Support Plan (BSP) dated June 30, 2007 on November 27, 2007 at approximately 1:15 PM revealed that targeted behaviors are to be recorded on the ABC forms. 2. The QMRP failed to coordinate services with Client #3's day program to ensure the use of the mealtime adaptive equipment recommended by the Occupational Therapist (OT) as evidenced by: Observation during breakfast at the group home on November 26, 2007 at approximately 6:35 AM revealed that Client #3 was served a pureed diet from a high sided plate. In an interview with the day program staff, on November 26, 2007 at	W 159	W159 1. See responses for W120 2. See responses for W120 3. The QMRP will train staff on menu-matched shopping to minimize the need for substitutions...12-30-07.	

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W 159	Continued From page 12 approximately 1:40 PM, it was revealed that Client #3 was served a pureed diet from an interlip plate. Further interview and Record review revealed that Client #3 had mealtime protocol at the day program dated February 1, 2007 which indicated that the client's adaptive equipment was a plate guard and a regular cup with a straw. Review of the Occupational Therapist (OT) Assessment dated June 16, 2007, on November 26, 2007 at approximately 3:30 PM revealed that Client #3 was recommended to use a high sided plate and a plate guard at mealtime. There was no evidence Client #3 was served a pureed diet from a high sided plate as recommended by the OT in the day program. 3. The QMRP failed to ensure that the facility had the food items available for breakfast as recommended by the nutritionist as evidenced below: Observation of the breakfast meal on November 26, 2007 at approximately 6:35 AM revealed that all clients were served juice, scrambled eggs, grits, a slice of wheat toast and a glass of skim milk according to their specific textures. Interview with staff on November 26, 2007 on November 26, 2007 at approximately 7:10 AM revealed that turkey bacon was on the menu for breakfast but that the facility did not have any turkey bacon. Observation of the refrigerator contents on November 26, 2007 at approximately 7:12 AM verified that the facility did not have turkey bacon or a meat substitute available in the facility. Review of the Nutritionist's menu on November 26, 2007 at approximately 7:15 AM revealed that turkey bacon was on the menu for breakfast. There was no evidence that the facility had the food items available for breakfast as	W 159	The nutritionist will provide a list if appropriate substitutes for the menu items and staff will use the listed items exclusively if substituting becomes necessary...1-2-08	

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W 159	Continued From page 13 recommended on the nutritionist's menu. 4. The facility's QMRP failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and maintained as evidenced by: Observation of Client #3's wheelchair on November 27, 2007 on at approximately 8:30 AM revealed that the wheelchair did not have bi-lateral footrests. In an interview with the QMRP on November 27, 2007 at approximately 1:55 PM it was acknowledged that Client #3's wheelchair did not have bi-lateral footrests. Review of the Physical Therapist's (PT) assessment dated October 6, 2007 on November 26, 2007 at approximately 9:55 AM revealed that Client #3 should use a wheelchair that had footrests for long distance travel. There was no evidence that the facility had provided the client with footrests on his wheelchair as recommended by the PT. 5. The QMRP failed to ensure that the facility maintained a sanitary environment to avoid sources and transmission of infection as evidenced by: Observations on November 26, 2007 approximately between the hours of between 4:50 PM-5:30 PM revealed that Client #2 and direct care staff washed their hands respectively on the same bar of ivory soap that was sitting on the sink outside the bathroom in the basement. In an interview with the QMRP it was acknowledged that the clients and staff used the same bar of soap after using the bathroom in the basement. There was no evidence that the facility maintained a sanitary environment to avoid sources and transmission of infection.	W 159	4. Footrests will be obtained for client #3's wheelchair by...12-30-07. The QMRP will insure that all needed adaptive equipment is in place and in good working order by auditing the adaptive equipment at minimum monthly...12-30-07. 5. The facility manager will insure that bar soap is available exclusively for the use of the individuals who live in the home and for their personal use only. Bathroom will routinely be stocked with liquid soap and paper towels...12-20-07. Nursing will train staff on infection control techniques and communicable disease control by...12-30-07. The facility manager will insure that all bathrooms are properly stocked with infection control materials by auditing the concern during weekly environmental inspections.....12-20-07.	

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W 159	Continued From page 14 6. The QMRP failed to coordinate services with the Speech/Language Pathologist to ensure that Client #3 had an annual assessment as evidenced by: Review of the Speech/Language assessment dated October 19, 2006 on November 26, 2007 at approximately 3:55 PM revealed that a modified Barium Swallow Study (January 14, 2003) indicated that Client #3 had mild pre-mature spillage of food over his tongue and absent chewing skills; and therefore, his food was pureed. Further review revealed a recommendation that an annual speech/language evaluation should be conducted. There was no evidence that the QMRP ensured that the client had an annual speech/language evaluation conducted or scheduled as recommended by the Speech and Language Pathologist. 7. The facility's QMRP failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and maintained as evidenced by: Observation on November 26, 2007 at approximately 6:30 AM revealed that Client #3 was wearing a blue helmet that was broken in the front and held together with duck tape. In an interview with the Registered Nurse (RN) on November 27, 2007 at approximately 2:14 PM, it was acknowledged that Client #3's helmet was broken and that a new helmet had been ordered. Review of the Individual Support Plan (ISP) dated December 11, 2006, on November 27, 2007 at approximately 8:00 AM revealed that Client #3 was recommended to use a helmet for safety.	W 159	6. The needed speech/language evaluation has been done. A copy is attached...12-30-07. 7. A new helmet had been ordered and received for client #3 prior to the beginning of the survey. The first new helmet sent was ill-fitting. It was sent back. It took [redacted] two weeks to secure a helmet that fit properly. Client #3 how has a new helmet that fits properly...12-15-07.	

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W 159	Continued From page 15 There was no evidence that Client #3 was provided a helmet that was in good repair. 8. The facility's QMRP failed to ensure that Client #1 was provided opportunities for continuous active treatment in accordance with his individual program plan (IPP) as evidenced by: During the observation period on November 26, 2007 at approximately 4:45 PM, Client #1 was observed to be visually impaired. Further observation revealed that Client #1 picked up two talking sensory devices and attempted to turn the devices on but the items did not work. Client #1 threw the talking sensory devices across the table and the direct care staff then redirected him to put together a puzzle. In an interview with the Qualified Mental Retardation Professional (QMRP) it was acknowledged that the batteries were inoperable in the talking sensory devices. Review of Client #1's medical assessment dated February 14, 2007 on November 27, 2007 at approximately 8:20 AM revealed that Client #1 has nystagmus in the left eye and a cataract in the right eye. The Speech/Language Assessment dated October 19, 2006 on November 27, 2007 at approximately 10:15 AM recommended that Client #1 be exposed to language stimulation activities to enhance his overall responses. There was no evidence that Client #1 was able to be engaged in language sensory activities as recommended. 9. The facility's QMRP failed to ensure each employee with adequate training in documenting on Client #1 and Client #2's bowel movement logs as evidenced by: a) Review of Client #1's bowel movement data	W 159	8. Client #1's communication devices now have batteries and the QMRP will insure that the home maintains a stock of batteries at all times so that the devices can routinely be used by client #1...12-20-07. The facility manager will audit the battery supply weekly...12-20-07.	

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W 159	Continued From page 16 sheets on November 27, 2007 at approximately 1:30 PM revealed that there was no documented data for the month of October, 2007. Further review revealed several blank spaces on the evening shift except for November 17, 24-25, 2007; several blank spaces on the night shift except for November 3-4, 10-11, 23, and 18-25, 2007. In an interview with the QMRP it was acknowledged that staff had not documented on the bowel movement log daily as recommended. There was no documented evidence that staff documented on Client #1's bowel movement data sheet daily. b) Review of Client #2's bowel movement data sheets on November 27, 2007 at approximately 1:40 PM revealed that there were several blank spaces on the morning shift on September 8, 22-23, 24-28,2007. In an interview with the QMRP it was acknowledged that staff had not documented on the bowel movement log daily as recommended. There was no documented evidence that staff documented on Client #2's bowel movement data sheet daily. 10. The facility's QMRP failed to ensure each employee with adequate training in documenting on Client #1 and Client #2's community outing logs as evidenced by: a) Review of Client #1's community outing data sheets on November 27, 2007 at approximately 1:35 PM revealed that during the morning shift on September 22-23, 25-26 and 28, 2007 the client washed clothing. In an interview with the QMRP it was acknowledged that staff had not documented correctly on the community outing log as recommended. There was no documented evidence that staff documented correctly on	W 159	9. Nursing will re-train the direct care staff on bowel movement charting.....12-30-07. The QMRP will audit the data weekly to insure it is consistently and properly collected and the facility manager will audit bi-weekly...12-20-07. 10. The QMRP flagged the error mentioned and re-trained the staff member in question prior to the beginning of the survey...11-20-07. No such errors have been made since by the staff member mentioned or others...12-20-07. Nursing will re-train staff on the use of client #3's gait belt...12-30-07. PT will follow up with further training...1-15-07.	

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W 159	Continued From page 17 Client #1's community outing data sheet daily. b) Review of Client #2's community outing data sheets on November 27, 2007 at approximately 1:45 PM revealed that on the morning shift on September 22, 26 and 28,2007 the client washed clothing. In an interview with the QMRP it was acknowledged that staff had not documented on the community outing log as recommended. There was no documented evidence that staff documented correctly on Client #2's community outing data sheet daily. 11. The facility's QMRP failed to ensure each employee with adequate training in consistently using Client #3's gait belt correctly as evidenced by: Observation on November 26, 2007 at approximately 9:00 AM revealed that Client #3 was wearing a gait around his waist. Further observation revealed that direct care staff would assist Client #3 in ambulating by holding the front of the gait belt. Interview with the direct care staff on November 26, 2007 at approximately 9:10 AM revealed that Client #3's gait belt was to be held on the side or in the back to prevent the client from from falling. Review of the Physical Therapy (PT) Assessment dated October 6, 2007 on November 26, 2007 at approximately 3:35 PM recommended that Client #3 was to use a gait belt for fall prevention. Further review revealed that the client ambulates slowly with decreased extremity ataxia. There was no evidence that staff was adequately trained on consistently using the client's gait belt correctly.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with	W 189		

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W 189	Continued From page 18 initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently for two of two clients in the sample (Client #1 and Client #2) and one focus client (Client #3) The findings include: 1. Review of Client #1's bowel movement data sheets on November 27, 2007 at approximately 1:30 PM revealed that there was no documented data for the month of October, 2007. Further review revealed several blank spaces on the evening shift except for November 17, 24-25, 2007; several blank spaces on the night shift except for November 3-4, 10-11, 23, and 18-25, 2007. In an interview with the QMRP it was acknowledged that staff had not documented on the bowel movement log daily as recommended. There was evidence that staff was adequately trained on how to document on Client #1's bowel movement data sheet daily. 2. Review of Client #2's bowel movement data sheets on November 27, 2007 at approximately 1:40 PM revealed that there were several blank spaces on the morning shift on September 8, 22-23, 24-28,2007. In an interview with the QMRP it was acknowledged that staff had not documented on the bowel movement log daily as	W 189	W189 See responses for W159 above.	

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W 189	Continued From page 19 recommended. There was evidence that staff was adequately trained on how to document on Client #2's bowel movement data sheet daily. 3. Review of Client #1's community outing data sheets on November 27, 2007 at approximately 1:35 PM revealed that during the morning shift on September 22-23, 25-26 and 28, 2007 the client washed clothing. In an interview with the QMRP it was acknowledged that staff had not documented correctly on the community outing log as recommended. There was no documented evidence that staff was adequately trained on how to document on Client #1's community outing data sheet. 4. Review of Client #2's community outing data sheets on November 27, 2007 at approximately 1:45 PM revealed that on the morning shift on September 22, 26 and 28,2007 the client washed clothing. In an interview with the QMRP it was acknowledged that staff had not documented on the community outing log as recommended. There was no documented evidence that staff was adequately trained on how to document on Client #2's community outing data sheet. 5. Observation on November 26, 2007 at approximately 9:00 AM revealed that Client #3 was wearing a gait belt around his waist. Further observation revealed that direct care staff would assist Client #3 in ambulating by holding the front of the gait belt. Interview with the direct care staff on November 26, 2007 at approximately 9:10 AM revealed that Client #3's gait belt was to be held on the side or in the back to prevent the client from from falling. Review of the Physical Therapy (PT) Assessment dated October 6, 2007 on November 26, 2007 at approximately 3:35 PM	W 189		

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W 189	Continued From page 20 recommended that Client #3 was to use a gait belt for fall prevention and that the client ambulates slowly with decreased extremity ataxia. There was no evidence that staff was adequately trained on consistently using the client's gait belt correctly.	W 189		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for four of four clients in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. The Qualified Mental Retardation Professional (QMRP) failed to ensure that all staff had been effectively trained to implement emergency measures for four of four clients in the facility as evidenced by: Interview with the QMRP November 28, 2007 at approximately 2:35 PM revealed that all staff was not trained in CPR. Record review on the same day at approximately 12:42 PM revealed that eight out of eleven staff including one Licensed Practical Nurse (LPN) did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. 2. The QMRP failed to ensure that all staff had been effectively trained to implement emergency	W 192	W192 1. CPR and First Aid training will be scheduled for all staff and nurses who need it by...12-30-07. MTS will track CPR and first aid training to insure that staff is current at all times. The QMRP will develop a January through June 2008 training calendar that insures that all mandated training is conducted at least once during the six month period...1-2-07. MTS will continue to train new staff in CPR and First Aid upon hire as part of their orientation training...1-2-07. 2. See above (#1).	

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W 192	Continued From page 21 measures for four of four clients in the facility as evidenced by: Interview with the QMRP November 28, 2007 at approximately 2:40 PM revealed that all staff was not trained in First Aid. Record review on the same day at approximately 12:42 PM revealed that five out of eleven staff including did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications.	W 192		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure that one out of two clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). (Client #1) The finding includes: During the observation period on November 26, 2007 at approximately 4:45 PM, Client #1 was observed to be visually impaired. Further observation revealed that Client #1 picked up two talking sensory devices and attempted to turn the	W 249	W249 See the responses for W159 (#8).	

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W 249	Continued From page 22 devices on but the items did not work. Client #1 threw the talking sensory devices across the table and the direct care staff then redirected him to put together a puzzle. In an interview with the Qualified Mental Retardation Professional (QMRP) it was acknowledged that the batteries were inoperable in the taking sensory devices. Review of Client #1's medical assessment dated February 14, 2007 on November 27, 2007 at approximately 8:20 AM revealed that Client #1 has nystagmus in the left eye and a cataract in the right eye. The Speech/Language Assessment dated October 19, 2006 on November 27, 2007 at approximately 10:15 AM recommended that Client #1 be exposed to language stimulation activities to enhance his overall responses. There was no evidence that Client #1 was able to be engaged in language sensory activities as recommended.	W 249		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the individual program plan (IPP) for one of the two clients in the sample (Client #1) and for one focus client (Client #3). The findings include:	W 312		

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W 312	Continued From page 23 1. Client #1 was observed during the morning medication pass on November 26, 2007 at approximately 7:45 AM being administered Ativan 4 mg by mouth. Interview with the Registered Nurse (RN) on November 26, 2007 at approximately 8:00 AM revealed that Client #1 was prescribed the sedation for a dental examination. Further interview revealed that the RN had no knowledge if a desensitization program for medical appointments had been developed for Client #1. Review of Client #1's medical records on November 27, 2007 at approximately 9:45 AM revealed that on November 20, 2006, the client received Ativan 4 mg by mouth prior to a dental exam, and on April 5, 2007 prior to a podiatry examination. Further review revealed that on May 14, 2007, the client received Ativan 4 mg by mouth for a dental exam. Interview with the Registered Nurse (RN) revealed that Client #1 did not have a desensitization program for medical appointments. Review of the Client #1's Individual Support Plan (ISP) dated December 11, 2006 on November 27, 2007 at approximately 11:00 AM, failed to evidence a program that addresses the client's non-compliant behaviors at medical appointments to justify the use of the sedative medication. There was no evidence that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the ISP. 2. Client #3 was observed during the morning medication pass on November 26, 2007 at approximately 8:00 AM being administered Ativan 4 4 mg by mouth. Interview with the RN on November 26, 2007 at approximately 8:05 AM revealed that Client #3 was prescribed the	W 312	W312 1. Psychology will develop a desensitization program for client #1 specific to his sedation issues by...1-2-07. 2. Psychology will develop a desensitization program for client #3 specific to his sedation issues by...1-2-07.	

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W 312	Continued From page 24 sedation for a dental examination. Interview with the Registered Nurse (RN) revealed that Client #3 did not have a desensitization program for medical appointments. Review of the Client #3's Individual Support Plan (ISP) dated December 11, 2006 on November 27, 2007 at approximately 11:10 AM, failed to evidence a program that addresses the client's non-compliant behaviors at medical appointments to justify the use of the sedative medication. There was no evidence that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the ISP.	W 312		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record reviewed, the facility failed to effectively train staff to implement emergency measures [Cross Refer to W192]; the facility failed to ensure that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the individual program plan (IPP) [Cross Refer to W312]; the facility's nursing services failed to ensure support staff received effective training on seizures [Cross Refer to W340]; failed to provide preventive and general health care services to meet the needs of the clients [Cross Refer to W322]; the facility failed to establish systems to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [Cross Refer to W331]; failed to ensure timely medical follow up	W 318	W318 The responses for W192, W312, W322, W331, W338, W368, W382 and others reflect the strategies and steps taken to correct the issues causing the Health Care Services Condition of Participation not to be met...1-2-07.	

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W 318	Continued From page 25 failed to ensure health services were provided to meet the needs of the clients [Cross Refer to W338]; and failed to ensure that medications were administered in accordance to physician's orders [Cross Refer to W368] and the facility failed to have a system to store all medications securely. [Cross Refer to W382] The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility's medical services failed to refer one of two clients in the sample to a specialist (Client #2) and the facility failed to provide a diet texture order on the physician's order sheet (POS) for one focus client included in the sample. (Client #3) The finding includes: 1. Observation during the breakfast meal on November 26, 2007 at approximately 6:35 AM revealed that Client #3 was served a pureed diet. Interview with the direct care staff on November 26, 2007 at approximately 7:05 AM revealed that all of Client #3's food was pureed for his safety. Review of the physician's order sheet (POS) dated October 1, 2007 on November 26, 2007 at approximately 3:50 PM revealed that Client #3 was on a low cholesterol diet with Resource Plus	W 322	W322 1. As mentioned, client #3 did receive a pureed diet during the survey and does routinely. The Physician's Orders reflect the pureed diet...12-30-07. Nursing and the PCP will review all new set of orders routinely to insure that they reflect the current drug regimen, treatment regimen and diet...12-30-07. The QMRP will review the clinical assessment recommendations and progress notes monthly to insure that any changes in the treatment regimen are picked up and properly implemented and documented...12-30-07. Nursing will schedule an appointment with a neurosurgeon to follow up on the right hand intrinsic atrophy as per PT's recommendation...12-30-07.	

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W 322	Continued From page 26 three times a day. Review of the Nutritional Assessment dated November 11, 2007 on November 26, 2007 at approximately 3:55 PM recommended that "puree" be added to Client #3's POS. There was no documented evidence that a pureed diet was included on the POS. 2. Review of the Physical Therapist (PT) assessment dated July 23, 2007, 2007 on November 27, 2007 at approximately 11:26 PM recommended that Client #2 be evaluated by a neurosurgeon to determine the culprit of his right hand intrinsic atrophy. Interview with the Registered Nurse (RN) on November 27, 2007 at approximately 12:26 PM revealed that Client #1 had not been evaluated by a neurosurgeon to determine the culprit of his right hand intrinsic atrophy. There was no documented evidence that Client #2 was evaluated or scheduled to be evaluated by a neurosurgeon to determine the culprit of his right hand intrinsic atrophy.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two clients in the sample. (Client #1 and Client #2) The findings include: 1. The facility's nursing staff failed to ensure that medications were given in compliance with the physician's orders for Client #1 as evidenced by:	W 331		

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W 331	Continued From page 27 Observation of the medication pass on November 26, 2006 at approximately 6:55 PM revealed that the Licensed Practical Nurse (LPN) was unable to administer Lactulose 15 ml. by mouth to Client #1 because the medication was not available in the facility. Review of the physician 's orders dated October 1, 2007, revealed an order to administer Lactulose 15 ml. by mouth every evening to Client #1. Review of a hospital discharge summary dated June 16, 2007 revealed that Client #1 had a Supravalvar Pulmonary Stenosis/LPA Stenosis performed on June 15, 2007. Further review revealed that the client was Status Post Pulmonary Balloon Valvuloplasty and LPA. In an interview with the LPN, it was acknowledged that the medication was not available in the facility because the pharmacist was unable to deliver the medication on November 26, 2007. Further interview revealed that the Lactulose would be delivered by the pharmacy on November 27, 2007. Interview with the Registered Nurse (RN) and observation of the contents of the medication file cabinet on November 28, 2007 at approximately 10:17 AM revealed that Client #1's Lactulose had not been delivered to the facility. There was no evidence that the medication prescribed by the physician was given in compliance with the physician's orders. 2. The facility's nursing staff failed to updated Client #1's Health Management Care Plan (HMCP) as evidenced by: Review of Client #1's Health Management Care Plan (HMCP) on November 27, 2007 at approximately 8:25 AM revealed that the HMCP had not been updated to include the client's diagnoses of Supravalvar Pulmonary	W 331	W331 1. As indicated, MTS nursing will meet with pharmacy to insure that medications are routinely obtained in a timely manner...12-30-07. See also the responses for W149 (second #3). 2. Client #1's Health Management Care Plan was modified to reflect issue and procedure described (see attachment)...12-1-07.	

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W 331	Continued From page 28 Stenosis/LPA Stenosis and Status Post Pulmonary Ballon Valvuloplasty and LPA. In an interview with the RN on November 20, 2007 at approximately 11:00 AM it was acknowledged that the HMCP had not been updated to include the client's Supravalvar Pulmonary Stenosis/LPA Stenosis and Status Post Pulmonary Ballon Valvuloplasty and LPA. There was no documented evidence that the HMCP had been updated after June 15, 2007 to include the new diagnoses. Review of a hospital discharge summary dated June 16, 2007 revealed that Client #1 had a Supravalvar Pulmonary Stenosis/LPA Stenosis performed on June 15, 2007.	W 331		
W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's nursing services failed to ensure timely follow-up on referrals in accordance with the needs of two of the two clients in the sample. (Client #1 and #2) The findings include: 1. The facility's nursing services failed to ensure that Client #1's cardiology appointment was conducted timely as evidenced below: Review of a hospital discharge summary dated June 16, 2007 on November 26, 2007 at	W 338		

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W 338	Continued From page 29 approximately 9:40AM revealed that Client #1 had a Supravalvar Pulmonary Stenosis/LPA Stenosis performed on June 15,2007 and was Status Post Pulmonary Balloon Valvuloplasty and LPA. Further review revealed a recommendation that Client #1 return to the cardiology clinic in one month. Interview with the Registered Nurse (RN) on November 27, 2007 at approximately 11:30AM revealed that Client #1 did return as scheduled to the cardiology clinic. Record review on November 27, 2007 at approximately 12:20 PM revealed that the client did not return to the cardiology clinic until August 22, 2007. There was no documented evidence that the client returned or was scheduled for the cardiology appointment in a timely manner. 2. The facility's nursing services failed to ensure that Client #1's audiology appointment was conducted timely as evidenced below: Review of an audiology consult dated June 23, 2006 on November 27, 2007 at approximately 8:38 AM revealed a recommendation that the client return to the audiology clinic after going to ENT to have a cerumen impaction removed from both ears. Interview with the RN on November 27, 2007 at approximately 8:35AM revealed that Client #1 is scheduled to go to the audiologist on November 29, 2007. Record review on November 27, 2007 at approximately 12:40 PM revealed that the client did not go to the ENT or back to the audiologist as recommended. There was no documented evidence that the client returned or was scheduled for an audiology appointment in a timely manner. 3. The facility's nursing services failed to ensure that Client #1 was scheduled for an ENT	W 338	W338 1 Cardiology follow up was scheduled for one month after the initial visit as per the doctor's request. The cardiologist rescheduled the appointment for August 22nd. Client #1 was seen on August 22nd, was fine and does not need to be seen again for four (4) years.....12-20-07. 2 Client #1 was seen by ENT on December 13th. Audiology will be scheduled by.....12-30-07. 3 See #2 above.	

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W 338	Continued From page 30 appointment as recommended by the Audiologist as evidenced below: Review of an audiology consult dated June 23, 2006 on November 27, 2007 at approximately 8:38 AM revealed a recommendation that the client return to the audiology clinic after going to ENT to have a cerumen impaction removed from both ears. Interview with the RN on November 27, 2007 at approximately 12:41PM revealed that Client #1 did not go and is not scheduled to go to ENT. Record review on November 27, 2007 at approximately 12:43 PM revealed that the client did not go to the ENT. There was no documented evidence that the client returned or was scheduled for an ENT appointment in a timely manner. 4. The facility's nursing staff failed to ensure that Client #1's laboratory studies were obtained in a timely manner as evidenced by: Review of physicians's order sheet (POS) dated October, 2007 on November 27, 2007 at approximately 8:50AM revealed a recommendation that the client have a Complete Blood Count (CBC), Liver Function Test (LFT), Lipid Profile and Dilantin levels every three months. Review of laboratory studies on November 27, 2007 at approximately 8:59AM revealed that the last laboratory studies were performed on March 20, 2007. Interview with the RN on November 27, 2007 at approximately 12:10 PM revealed that Client #1 did have laboratory studies performed as recommended by the Primary Care Physician (PCP). Review of a nutritional consult dated September 30, 2007 on November 27, 2007 at approximately 12:15 PM revealed that there were no "new labs". There	W 338	4 Client #1's level of cooperation presents a problem. The team will meet and develop a plan to successfully obtain the needed lab work. Team will meet by...12-28-07. The lab work will be obtained by...1-2-07.	

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W 338	Continued From page 31 was no documented evidence that the client had laboratory studies performed as recommended by the PCP. 5. The facility's nursing services failed to ensure that Client #1's neurology appointment was conducted timely as evidenced below: Review of a neurology consult dated March 14, 2006 on November 27, 2007 at approximately 8:38 AM revealed a recommendation that the client to return to the neurology clinic in one year. Review of Client #1's medical assessment dated February 14, 2007 on November 27, 2007 at approximately 7:30AM revealed that the client has a diagnosis of seizure disorder. Interview with the Registered Nurse (RN) on November 27, 2007 at approximately 12:45PM revealed that Client #1 is scheduled to go to the neurology clinic on November 28, 2007. Review of a nursing progress dated May 9, 2007 on November 27, 2007 at approximately 8:45AM stated "consumer needs neurology appointment". Record review on November 27, 2007 at approximately 12:47 PM revealed that the client did not return to the neurology clinic as recommended. There was no documented evidence that the client was scheduled for a neurology appointment in a timely manner. 6. The facility's nursing services failed to ensure that Client #1's ophthalmology appointment was conducted timely as evidenced below: Review of a POS dated October 1, 2007, on November 27, 2007 at approximately 8:40 AM revealed a recommendation that the client to return to the ophthalmology clinic annually. Record review on November 27, 2007 at	W 338	5 Neurology follow up was done for client #1 on ....11-29-07. 6 Client #1's ophthalmology appointment is scheduled for...1-22-07.	

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W 338	Continued From page 32 approximately 8:47AM revealed that the last documented time that Client #1 was assessed by an ophthalmologist was on March 23, 2005. Review of Client #1's medical assessment dated February 14, 2007on November 27, 2007 a approximately 8:50AM revealed that Client #1 has nystagmus in the left eye and a cataract in the right eye. Interview with the RN on November 27, 2007 at approximately 12:49PM revealed that Client #1 is scheduled to go to the ophthalmology clinic on January 22, 2008. There was no documented evidence that the client was scheduled for an ophthalmology appointment in a timely manner. 7. The facility's nursing staff failed to ensure that Client #2's CBC and LFT laboratory studies were obtained in a timely manner as evidenced by: Review of physicians's order sheet (POS) dated September 26, 2007 on November 27, 2007 at approximately 12:00 PM revealed a recommendation that the client have a CBC and LFT every three months. Review of laboratory studies on November 27, 2007 at approximately 12:34 PM revealed that the last laboratory studies were obtained on March 1, 2007. Interview with the RN on November 27, 2007 at approximately 12:11 PM revealed that Client #1 did have laboratory studies obtained as recommended by the Primary Care Physician (PCP). There was no documented evidence that the client had his CBC and LFT obtained every three months as recommended by the PCP. 8. The facility's nursing staff failed to ensure that Client #2's Depakote levels were obtained in a timely manner as evidenced by:	W 338	7 The RN will develop a schedule for serum lab follow up for each person supported that reflects their needs as mandated by their ISPs, physicians orders, the clinical assessments and by their Health Management Care Plans...12-30-07. 8 See #7 above.	

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W 338	Continued From page 33 Review of physicians's order sheet (POS) dated September 26, 2007 on November 27, 2007 at approximately 12:01 PM revealed a recommendation that the client have Depakote levels obtained every three months for the management of Schizophrenia. Review of laboratory studies on November 27, 2007 at approximately 12:35 PM revealed that there were no Depakote levels on file. Interview with the RN on November 27, 2007 at approximately 12:12 PM revealed that Client #1 did have his Depakote levels obtained every three months as recommended by the PCP. There was no documented evidence that the client had Depakote levels obtained every three months as recommended by the PCP. 9. The facility's nursing staff failed to ensure that Client #2's chemistry laboratory studies were obtained in a timely manner as evidenced by: Review of POS dated September 26, 2007 on November 27, 2007 at approximately 12:02 PM revealed a recommendation that the client have chemistry levels obtained every three months. Review of laboratory studies on November 28, 2007 at approximately 3:34 PM revealed that the only chemistry levels on file were obtained on November 14, 2007. Interview with the RN on November 27, 2007 at approximately 12:11 PM revealed that Client #1 did have chemistry laboratory studies obtained every three months as recommended by the PCP. There was no documented evidence that the client had his chemistry levels obtained every three months as recommended by the PCP. 10. The facility's nursing services failed to ensure that Client #2's neurology appointment was	W 338	9 See #7 above	

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W 338	Continued From page 34 conducted timely as evidenced below: Review of a neurology consult dated February 9, 2007 on November 27, 2007 at approximately 11:47AM revealed a recommendation for Client #2 to have a MRI of the Brain and Cervical Spine. Further review revealed a recommendation that the client to return to the neurology clinic in six weeks. Review of Client #2's medical consult dated March 2, 2007 on November 27, 2007 at approximately 11:50AM revealed that the MRI of the Brain and Cervical Spine was not perfomed. Interview with the RN on November 27, 2007 at approximately 1:50PM revealed that Client #2's parents would not sign the consult for the MRI of the Brain and Cervical Spine. Further interview revealed that it is unknown whether or not the neurologist is aware that Client #2 did not have the MRI of the Brain and Cervical Spine performed. Record review on November 27, 2007 at approximately 1:52 PM revealed that the client did not return to the neurology clinic as recommended. There was no documented avidence that the client returned to the neurology clinic in six weeks as recommended.	W 338	10 MTS will try again to get consent form the parents of client #2 for the MRI and will involve the physician in the risks/benefits discussion. Should consent be obtained, the procedure will be scheduled as soon as possible thereafter. The parents will be interviewed by...12-30-07. Neurology follow up will be scheduled for client #2 by...1-2-07. MTS has revised its nursing staff to include: • DON • Three full time RNs and two Consultants covering all of the homes and individuals served with reasonable caseloads. • Three support LPNs (two full- time, one part time) to support the RNs with medical appointments, medication and supply ordering and other tasks. • A consulting medication nursing pool. The new configuration provides the manpower needed to effectively manage the needs of all of the individuals supported...12-1-07. In addition, RNs, QMRPs and facility managers of each home meet monthly to discuss medical concerns and the nursing team meets with the DON monthly to review the status of follow up...12-1-07. Audit tools have been revised to reflect all key concern areas...12-1-07.	
W 340	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility's nursing services failed to ensure support staff received effective training on	W 340		

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W 340	Continued From page 35 seizures for one of two clients in the sample. (Client #1) The finding includes: Observations of the evening medication administration conducted on November 28, 2007 at approximately 6:55 PM revealed Client #1 was administered Dilantin 50 mg for seizures. Interview with the facility Registered Nurse (RN) on November 28, 2007 at approximately 1:01 PM revealed that Client #1 has a diagnosis of seizure disorder and is the only client in the facility that is administered medications for seizures. Further interview with the RN revealed that she had not provided seizure training to the direct care staff. The RN stated that "she has to do this." Review of the in service training records on the same day at 11:42 AM revealed no documented evidence that staff had received training on seizures.	W 340	W340 Nursing will train staff on seizure disorders by...12-30-07.	
W 350	483.460(e)(3) DENTAL SERVICES The facility must provide education and training in the maintenance of oral health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that training on tooth brushing was provided as recommended to two of two clients in the sample. (Client #1 and Client #2) The findings include: 1. The facility failed to ensure that Client #1 and Client #2 received training as prescribed to improve their tooth brushing skills. a. Record review revealed that during Client #1's	W 350		

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W 350	Continued From page 36 dental examination on May 14, 2007, the dentist diagnosed the client with poor oral hygiene and recommended that the client brush his teeth two to three times a day. Interview with the Qualified Mental Retardation Professional (QMRP) on November 27, 2007 at approximately 8:40 AM revealed that direct care staff supervise/assist the client in brushing his teeth in the AM and PM. Review of the Individual Support Plan (ISP) dated December 11, 2006, revealed that the Client #1 did not have a tooth brushing program. There was no evidence that the client was brushing his teeth two to three times daily as prescribed by the dentist. b. Record review revealed that during Client #2's dental examination on September 28, 2007, the dentist diagnosed the client with poor oral hygiene and he had teeth #29 and #30 extracted. Further review revealed a recommendation that the client brush his teeth two to three times a day. Interview with the Qualified Mental Retardation Professional (QMRP) on November 26, 2007 revealed that direct care staff supervise/assist the client in brushing his teeth in the AM and PM. Review of the Individual Support Plan (ISP) dated August, 2007, revealed that the Client #1 did not have a tooth brushing program. There was no evidence that the client was brushing his teeth two to three times daily as prescribed by the dentist.	W 350	W350 Both clients mentioned (#1 and #2) have been trained on tooth brushing in the past and at this point perform at their maximum potential. Both will always need staff assistance to competently complete the task. The activity schedules of each will be modified to reflect the times tooth brushing is done for each...12-30-07. In addition, protocols will be developed instructing staff on how to support each in completing the tooth brushing task...12-30-07. Also, electric tooth brushes will be purchased for each to see if they are tolerated and if they improve each person's level of independence...12-30-07.	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by:	W 368		

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W 368	Continued From page 37 Based on staff interview and record review, the facility failed to ensure that medications were given in compliance with the physician's orders for one of two clients in the sample. (Client #1) The finding includes: Observation of the medication pass on November 26, 2006 at approximately 6:55 PM revealed that the Licensed Practical Nurse (LPN) was unable to administer Lactulose 15 ml. by mouth to Client #1 because the medication was not available in the facility. Review of the physician 's orders dated October 1, 2007, revealed an order to administer Lactulose 15 ml. by mouth every evening to Client #1. In an interview with the LPN, it was acknowledged that the medication was not available in the facility because the pharmacist was unable to deliver the medication on November 26, 2007. There was no evidence that the medication prescribed by the physician was given in compliance with the physician's orders.	W 368	W368 See the responses forW149 (#8).	
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation of the medication administration, the facility's medication nurse failed to ensure all biological and drugs were locked when not being prepared The finding includes: Observation on November 26, 2006,	W 382		

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W 382	Continued From page 38 approximately between the hours of 4:05 PM-6:30 PM revealed that the combination lock that was used to secure the medication file cabinet located in the basement was lying on a counter top. Further observation revealed that during that same time period, Client's #1, #2, #3, and #4 and unlicensed direct care staff were involved in various active treatment programs in the basement. The medication Licensed Practical Nurse (LPN) placed the combination lock on the medication file cabinet before going upstairs to wash her hands. In an interview with the Registered Nurse (RN) on November 27, 2006, approximately 2:00 PM it was acknowledged that the medication file cabinet is to be locked at all times when medications are not being prepared. There was no evidence that the medication file cabinet was locked when medications were not being prepared.	W 382	W382 See the responses for W149 (last paragraph).	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that clients were provided with the necessary adaptive equipment for the focus client included in the sample. (Client #3) The findings included:	W 436		

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W 436	Continued From page 39 1. Observation of Client #3's wheelchair on November 27, 2007 at approximately 8:30 AM revealed that the wheelchair did not have bi-lateral footrests. In an interview with the QMRP on November 27, 2007 at approximately 1:55 PM it was acknowledged that Client #3's wheelchair did not have bi-lateral footrests. Review of the Physical Therapist's (PT) assessment dated October 6, 2007 on November 26, 2007 at approximately 9:55 AM revealed that Client #3 should use a wheelchair that had footrests for long distance travel. There was no evidence that the facility had provided the client with footrests on his wheelchair as recommended by the PT. 2. Observation during breakfast at the group home on November 26, 2007 at approximately 8:35 AM revealed that Client #3 was served a pureed diet from a high sided plate. In an interview with the day program staff, on November 26, 2007 at approximately 1:40 PM, it was revealed that Client #3 was served a pureed diet from an interlip plate. Further interview and Record review revealed that Client #3 had mealtime protocol at the day program dated February 1, 2007 which indicated that the client's adaptive equipment was a plate guard and a regular cup with a straw. Review of the Occupational Therapist (OT) Assessment dated June 16, 2007, on November 26, 2007 at approximately 3:30 PM revealed that Client #3 was recommended to use a high sided plate at mealtime. There was no evidence Client #3 was provided a high sided plate as recommended by the OT in the day program. 3. Observation on November 26, 2007 at approximately 6:30 AM revealed that Client #3 was wearing a blue helmet that was broken in the	W 436	W436 See the responses for W120 (#1) (high sided plate) See responses for W159 (4) (footrests) See responses for W159 (7) (helmet)	

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W 436	Continued From page 40 front and held together with duck tape. In an interview with the Registered Nurse (RN) on November 27, 2007 at approximately 2:14 PM, it was acknowledged that Client #3's helmet was broken and that a new helmet had been ordered. Review of the Individual Support Plan (ISP) dated December 11, 2006, on November 27, 2007 at approximately 8:00 AM revealed that Client #3 was recommended to use a helmet for safety. There was no evidence that Client #3 was provided a helmet that was maintained in good repair.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on November 28, 2007 at approximately 10:19 PM revealed the scheduled shifts are as follows: Weekdays 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM 3rd Shift 10 AM to 8 AM Weekends/Saturday and Sunday 1st 8 AM to 8 PM	W 440	W440 The 2008 fire drill schedule will reflect drills occurring by schedule for all staff shifts at least once per quarter (see attached schedule)...12-30-07. The QMRP and facility manager will review the documentation monthly to insure drills occurred as planned. Missed drills will be made up by the relevant shift within seven (7) days of the date missed...1-2-07. Between December 2007's remainder and January of 2008, Northampton will hold fire drills weekly in order to insure that each shift holds a drill in the next six weeks.....1-30-07.	

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W 440	Continued From page 41 2nd 8 PM to 8 AM Further interview with the QMRP revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log book from December 2006 to November 28, 2007 revealed that the facility failed to hold fire evacuation drills for the third shift on the weekdays. There was no evidence that fire drills were conducted quarterly on all shifts.	W 440		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: Review of the facility's fire drill records on November 28, 2007 at approximately 10:19 AM revealed that most of the fire drills were conducted via the front and back door exits. Interview with the Qualified Mental Retardation Professional (QMRP) and the facility's Registered Nurse (RN) at approximately 10:28 AM revealed that the facility had at least four method of egress. Further interview with the QMRP revealed that there's an exit through Client #2's bedroom located on the third floor and there's an exit located in the basement where active treatment is rendered daily. Further review of the fire drill record revealed that the exit to basement and Client #2's bedroom had not been used at any time. There was no evidence that evacuation	W 441	W441 Staff will be trained by the fire safety consultant on using all egress points and other fire safety issues by...1-2-07. The QMRP will review the fire drill documentation monthly to insure the nearest exists are used given the specific circumstances each drill presents...1-2-07. Follow up training will occur if staff do not...1/07.	

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W 441	Continued From page 42 drills were held under varied conditions.	W 441		
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection. The finding includes: Observations on November 26, 2007 approximately between the hours of 4:50 PM-5:30 PM revealed that Client #2 and direct care staff washed their hands respectively on the same bar of Ivory soap that was sitting on the sink outside the bathroom in the basement. In an interview with the QMRP it was acknowledged that the clients and staff used the same bar of soap after using the bathroom in the basement. There was no evidence that the facility maintained a sanitary environment to avoid sources and transmission of infection.	W 454	W441 Staff will be trained by the fire safety consultant on using all egress points and other fire safety issues by...1-2-07. The QMRP will review the fire drill documentation monthly to insure the nearest exists are used given the specific circumstances each drill presents...1-2-07. Follow up training will occur if staff do not...1/07. W454 See the responses for W159 (#5)	

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I 000	INITIAL COMMENTS A recertification survey was conducted from November 26, 2007 through November 28, 2007. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a resident population of four males with various disabilities. An additional resident was added as a focus to determine if the resident was provided with the necessary adaptive equipment. The survey findings were based on observations in the group home and two day programs, and interviews with residents, residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted. The facility found in violation of D.C. licensure requirements.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure blinds and curtains at each window. The findings include: Observation of the environment conducted on November 28, 2007 at beginning at 1:49 PM revealed the following: 1. There were no curtains, blinds or shades in the window to the backdoor located in the kitchen. 2. There were no curtains, blinds or shades in the	I 022	3501.5 1. The kitchen back door will be covered by curtains, blinds or a shade by.....12-30-07. 2. Same as above for the window near the dryer in the basement...12-30-07.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Director of Residential Services TITLE (X6) DATE 12/6

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I 022	Continued From page 1 window near the dryer in the basement.	I 022		
I 040	3502.1 MEAL SERVICE / DINING AREAS Each GHMRP shall provide each resident with a nourishing, well-balanced diet. This Statute is not met as evidenced by:	I 040		
I 060	3502.18 MEAL SERVICE / DINING AREAS Perishable foods shall be stored at proper temperatures in order to conserve nutritive value. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that equipment necessary for monitoring refrigeration temperatures was provided. This finding includes: Observation revealed no thermometer was in the deep freezer located in the basement. Interview with Qualified Mental Retardation Professional (QMRP) on November 28, 2007 at approximately 2:15 PM acknowledged that there was no thermometer in the deep freezer.	I 060	3502.18 A new thermometer was placed in the freezer by...12-1-07.	
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.	I 082		

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I 082	Continued From page 2 This Statute is not met as evidenced by: Based on observations and Interview at the GHMRP failed properly equip each bathroom with the appropriate items to meet each residents need. The findings include: During the environmental walk-through on November 28, 2007 beginning at 1:49 PM revealed the following: 1. The bathroom located on the third level utilized on Resident #1, #2, and #3 was observed to be missing a light bulb located over the sink. 2. The bathroom located on the third level utilized on Resident #4 was observed to be missing two light bulbs located over the sink.	I 082	3503.10 1. Bathroom light bulb replaced...12-1-07. 2. Light bulbs over sink replaced...12-1-07. The facility manager will audit the environment weekly to address such issues as they arise...12-1-07.	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. On November 28, 2007 an environment walk thru was conducted and revealed the following	I 090		

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I 090	Continued From page 3 deficiencies: Kitchen 1. Cabinets located in the kitchen was observed to be have sticky substance on them. 2. Onions peelings was observed left in the drawer located left of the refrigerator. Bathrooms 1. The shower knobs located in the bathroom on the third level utilized by Residents #1, #2, and #3 was observed with build-up (Mildew). 2. Resident #4's bottom of the shower was observed to have build-up (Mildew).	I 090	3504.1 1. Kitchen cabinets were cleaned by 12-1-07 and are cleaned on a routine daily basis...12-1-07. 2. Onion peelings were removed 11-29-07. Staff will insure that the drawers are closed when they and the individuals supported perform meal preparation tasks like peeling vegetables...12-1-07. 3. The shower knobs were cleaned the same day and are routinely cleaned along with the entire shower on a daily basis after each shower...12-1-07. 4. The bottom of the shower was cleaned but will be reviewed b y maintenance. If need be it will be scrapped and repainted by...1-2-07.	
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to maintain the interior and exterior of the GHMRP in a in a safe, clean, orderly, attractive, and sanitary manner. The finding includes: Observation and interview with the Qualified Mental Retardation Professional (QMRP) during the environmental walk through on November 28, 2007 beginning at 1:49 PM revealed the following:	I 091		

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I 091	Continued From page 4 Kitchen 1. The top drawer located between the oven and kitchen sink was observed to be missing. 2. The second drawer located between the oven and kitchen was detached from it's base. 3. The knob that turns on the fan over the stove was missing. 4. There was no vent cover covering the fan located over the stove. The fan was observed to be turning at the time of the survey. 5. There was a rusted pan located under the cabinet. Bedrooms Knobs were missing on the top and second drawers in Resident # 2's bedroom.	I 091	3504.2 1. The kitchen drawer will be replaced by...12-30-07. 2. The second kitchen drawer will also be replaced by... 12-30-07. 3. The stove knob will be replaced by...12-30-07. 4. A vent will be put in place for the stove fan by...12-30-07. 5. The rusted pan was discarded and will be replaced by...12-30-07. The drawer knobs (resident#2) will be replaced by...12-30-07. As mentioned the facility manager will audit, report and address such issues weekly.....12-1-07.	
I 135	3505.6 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the GHRMP failed to hold evacuation drills quarterly on all shifts and under varied conditions. The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing	I 135		

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I 135	Continued From page 5 pattern on November 28, 2007 at approximately 10:19 PM revealed the scheduled shifts are as follows: Weekdays 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM 3rd Shift 10 AM to 8 AM Weekends/Saturday and Sunday 1st 8 AM to 8 PM 2nd 8 PM to 8 AM Further interview with the QMRP revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log book from December 2006 to November 28, 2007 revealed that the facility failed to hold fire evacuation drills for the third shift on the weekdays. There was no evidence that fire drills were conducted quarterly on all shifts. 2. Review of the facility's fire drill records on November 28, 2007 at approximately 10:19 AM revealed that most of the fire drills were conducted via the front and back door exits. Interview with the Qualified Mental Retardation Professional (QMRP) and the facility's Registered Nurse (RN) at approximately 10:28 AM revealed that the facility had at least four method of egress. Further interview with the QMRP revealed that there's an exit through Client #2's bedroom located on the third floor and there's an exit located in the basement where active treatment is rendered daily. Further review of the fire drill record revealed that the exit to basement and Client #2's bedroom had not been used at any time. There was no evidence that evacuation drills were held under varied conditions.	I 135	The 2008 fire drill schedule will reflect drills occurring by schedule for all staff shifts at least once per quarter (see attached schedule)...12-30-07. The QMRP and facility manager will review the documentation monthly to insure drills occurred as planned. Missed drills will be made up by the relevant shift within seven (7) days of the date missed...1-2-07. Between December 2007's remainder and January of 2008, Northampton will hold fire drills weekly in order to insure that each shift holds a drill in the next six weeks.....1-30-07.	

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I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and review of records, the GHMRP failed to establish and maintain a system that ensures a complete and accurate accounting of residents' funds that are entrusted to the facility for two of two clients included in the sample. (Resident #1 and #2) The finding includes: Review of Residents #1 and #2 financial records on November 28, 2007 at approximately 1:36 PM revealed that there were no full and complete accounting of the residents personal funds available for review in the facility. Interview with the Qualified Mental Retardation Professional (QMRP) acknowledged that there were no full and complete accounting for Residents' #1 and #2 personal funds.	I 189	1 and 2. Copies of the vacation receipts are attached for clients #1 and #2. MTS will insure that personal funds use receipts are reconciled in a timely manner in the future. MTS has assigned this task to a specific member of the accounting office team and has revised its policies to reflect the regulatory mandates...12-30-07.	
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: Review of the personnel files conducted on November 28, 2007 at approximately 12:42 PM	I 203	3509.3 All five of the staff members mentioned have had their job descriptions reviewed with them by their supervisor as evidenced by the signed copies attached...12-30-07. MTS is tracking ongoing compliance via its new tracking tool (attached)...12-1-07.	

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I 203	Continued From page 7 revealed the GHMRP failed to provide evidence of current signed job descriptions for of five of eleven staffs. (S#1, #2, #6, #7, and #8)	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The findings include: 1. Review of the personnel files conducted on November 28, 2007 at approximately 12:42 PM revealed the GHMRP failed to provide evidence of current current health certificates for four of eleven staffs. (S#1, #6, #7, and #8) 2. Review of the personnel files conducted on November 28, 2007 at approximately 1:16 PM revealed the GHMRP failed to provide evidence of current current health certificates for seven consultants. (C#3, #4, #5, #8, 10, and #11)	I 206	3509.6 Staff and consulting professional mentioned will have updated health certificates by.....12-30-07.	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I 227		

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I 227	Continued From page 8 (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHRMP failed to effectively train staff to implement emergency measures for four of four clients in the facility. (Residents #1, #2, #3 and #4) The findings include: 1. The Qualified Mental Retardation Professional (QMRP) failed to ensure that all staff had been effectively trained to implement emergency measures for four of four residents in the facility as evidenced by: Interview with the QMRP November 28, 2007 at approximately 2:35 PM revealed that all staff was not trained in CPR. Record review on the same day at approximately 12:42 PM revealed that eight out of eleven staff including one Licensed Practical Nurse (LPN) did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. (S#2, #3, #4, #5, #7, #8, #9, and LPN #3) 2. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for four of four residents in the facility as evidenced by: Interview with the QMRP November 28, 2007 at approximately 2:40 PM revealed that all staff was not trained in First Aid. Record review on the same day at approximately 12:42 PM revealed that five out of eleven staff including did not have current First Aid certifications. There was no	I 227	1. CPR and First Aid training will be scheduled for all staff and nurses who need it by...12-30-07. MTS will track CPR and first aid training to insure that staff is current at all times. The QMRP will develop a January through June 2008 training calendar that insures that all mandated training is conducted at least once during the six month period...1-2-07. MTS will continue to train new staff in CPR and First Aid upon hire as part of their orientation training...1-2-07. 2. See above (#1).	

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I 227	Continued From page 9 documented evidence that all direct care staff had First Aid training and current First Aid certifications. (S#3, #4, #5, #7, and #9)	I 227		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and review of training documents, the GHMRP failed to provide evidence to validate staff training as indicated by residents' need. The finding includes: Review of the training records on November 28, 2007 at approximately 11:13 AM revealed, the GHMRP failed to provide training on sexuality, human development, and recreations. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 2:30 PM acknowledged that the staff had not received training in this area.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living	I 379		

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I 379	Continued From page 10 arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: 1. On November 27, 2007 at approximately 11:00 AM a nursing progress note dated August 1, 2007 was reviewed and revealed that Resident #1 was discovered to have two 5.5 cm scratches of unknown origin on his body. Interview with the Registered Nurse (RN) on November 27, 2007 at 2:10 PM revealed that she had not completed an unusual incident report for the facility's incident manager to forward to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required. 2. Review of an unusual incident report dated May 26, 2007 on November 26, 2007 at approximately 8:17 AM revealed that Resident #3 had sustained scratches on his penis and was transported to the emergency room for treatment. Further review revealed that the DOH was not made aware of the incident until June 4, 2007. There was no documented evidence that this incident had been reported to governmental agencies as required in a timely manner.	I 379	1. The DON will train nursing staff on the incident reporting mandates by.....12-30-07. 2. The IMC was not informed via incident report with 24 hours. The residential director has reinforced with the QMRP the importance of insuring that reports are submitted to the IMC immediately so that she can properly distribute them.....12-30-07. The residential director will reinforce this with the entire management team in the July 2008 team meeting...1-20-07. 3. The Don will also reinforce with nursing the policy on discarding expired medications....12-30-07.	

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I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of licensed professional staff secured by the group home to monitor interventions, in accordance with the goals and objectives of every individual habilitation plan. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on November 28, 2007 and review of the personnel records on November 28, 2007 at approximately 1:16 PM revealed the GHMRP failed to provide evidence of a current license on file for the primary care physician.	I 391	3520.2 (a) A copy of the PCP current license is attached...12-1-07. 3520.2 (e) Copy of the DON's current license and that of LPN #2 are attached...12-1-07.	
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in	I 395		

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I 395	Continued From page 12 accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure its nurses had current licenses on file. The finding includes: Review of the personnel records on November 28, 2007 at approximately 1:16 PM revealed the GHMRP failed to have current license on file for the Director of Nursing (DON) and one licensed practical nurse. (LPN #2)	I 395		
I 398	3520.2(h) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (h) Social Work;	I 398	3520.2 (h) A copy of the social worker's current license is attached...12-1-07.	

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I 398	Continued From page 13 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure its nurses had current licenses on file. The finding includes: Interview with the QMRP and review of the personnel records on November 28, 2007 at approximately 1:16 PM revealed the GHMRP failed to have current license on file for the social worker.	I 398		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the provision of recommended medical/lab examinations for two of two residents in the sample (Resident #1 and Resident #2); to include the correct diet texture on the physician's order sheet (POS) for one focus resident (Resident #3) and to update the Health Management Care Plan (HMCP) for one resident in the sample (Resident #2). The findings include: 1. Observation during the breakfast meal on November 26, 2007 at approximately 6:35 AM revealed that Resident #3 was served a pureed	I 401	1. MTS will insure that the day program of client #3 has the same type of high sided plate used at home and will purchase one for the program if need be by...12-30-07. The QMRP will visit the program at minimum once monthly to insure that the program staff is routinely using the proper plate and following the prescribed diet...12-30-07.	

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I 420	Continued From page 24 6. The QMRP failed to coordinate services with the Speech/Language Pathologist to ensure that Resident #3 had an annual assessment as evidenced by: Review of the Speech/Language assessment dated October 19, 2006 on November 26, 2007 at approximately 3:55 PM revealed that a modified Barium Swallow Study (January 14, 2003) indicated that Resident #3 had mild pre-mature spillage of food over his tongue and absent chewing skills and therefore his food was pureed. Further review revealed a recommendation that Resident #3 have an annual speech/language evaluation. There was no evidence that the QMRP ensured that the resident had an annual speech/language evaluation conducted or scheduled. 7. The facility's QMRP failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and maintained as evidenced by: Observation on November 26, 2007 at approximately 6:30 AM revealed that Resident #3 was wearing a blue helmet that was broken in the front and held together with duck tape. In an interview with the Registered Nurse (RN) on November 27, 2007 at approximately 2:14 PM, it was acknowledged that Resident #3's helmet was broken and that a new helmet had been ordered. Review of the Individual Support Plan (ISP) dated December 11, 2006, on November 27, 2007 at approximately 8:00 AM revealed that Resident #3 was recommended to use a helmet for safety. There was no evidence that Resident #3 was provided a helmet that was in good repair.	I 420	6. The needed speech/language evaluation has been done. A copy is attached…12-30-07. 7. A new helmet had been ordered and received for client #3 prior to the beginning of the survey. The first new helmet sent was ill-fitting. It was sent back. It took Family Medical two weeks to secure a helmet that fit properly. Client #3 now has a new helmet that fits properly…12-15-07. 8. Client #1's communication devices now have batteries and the QMRP will insure that the home maintains a stock of batteries at all times so that the devices can routinely be used by client #1…12-20-07.	